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AUTHOR Poster, Elizabeth C.
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ABSTRACT

Questions associated with an alternative approach to preparing nursery and elementary school children for hospitalization are addressed, and the basic components of a pre-crisis curriculum are outlined in this paper. Questions broached focus on (1) the effectiveness of a general curriculum approach as opposed to a crisis approach to preparing children for hospitalization, (2) justification for the preparation program in terms of annual number of children hospitalized, and (3) the stressful nature of hospital experience as a warrant for intervention. Several features of the process of stress immunization (also called stress innoculation or psychological immunization) are pointed out to provide indirect support for early preparation of healthy children for hospitalization. Currently used crisis-oriented intervention strategies are listed according to their goals, and the goals and key elements of a supplementary pre-crisis curriculum for primary intervention which uses stress immunization techniques and provides for parent participation are indicated. Central focuses for program evaluation are noted. (RH)

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RATIONALE AND GUIDELINES FOR A PRE-CRISIS CURRICULUM TO PREPARE HEALTHY PRESCHOOL CHILDREN FOR HOSPITALIZATION

Octoberquest '82

Presenter: Elizabeth C. Poster, R.N., Ph.D.
Assistant Professor
U.C.L.A.

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Support for the importance of psychological preparation for pediatric patients and their families can be seen in the widespread development of pre-admission preparation programs. A 1980 national survey found that 70 percent of all non-chronic care pediatric hospitals have pre-hospital preparation programs. While all these programs are designed to lessen the psychological upset which accompanies the experience of hospitalization, few research studies clearly demonstrate the effectiveness of these programs.

All these preparation programs are intended for children already scheduled for surgery or medical care. One of the basic questions that needs to be answered regarding pre-admission preparation is: Is preparation just prior to or during hospitalization adequate? Would preparation be more effective if it were begun earlier--at a time when children are well and not faced with the stress of imminent hospitalization?

Another question of importance is: Are large enough numbers of children hospitalized annually so as to justify the development of early preparation programs? And lastly, is the experience of hospitalization inherently so stressful that its effect on the child warrants the spending of time, energy and money on an alternative approach to psychological preparation?

This presentation will answer these questions and propose an alternative approach to current pre-admission preparation programs. This alternative is a pre-crisis curriculum which would prepare healthy young children for hospitalization in nursery and elementary schools. In

addition, the basic components of such a curriculum will be outlined. The implications for evaluative research will also be briefly reviewed.

The first question to answer is: Would a general preparation for hospitalization be more effective if it were initiated at some time prior to the child's actual need for hospitalization? This is a difficult question to answer because there is no research in this area. While a number of nursery and elementary schools bring their students on tours of local hospitals and talk about the children's concerns, none has formally evaluated the outcomes of these experiences. Also, these hospital tours are not part of a preparatory curriculum. They are usually isolated experiences with little preparation and follow-up.

Although direct evidence to support early preparation of healthy chidren for hospitalization is not available, indirect support from stress research has applicability. The process of stress immunization--also referred to in the literature as stress innoculation, or psychological immunization--provides the rationale for early preparation for hospitalization. This process has a number of features:

L. It prepares individuals for future stress by exposing them to small manageable does of the stressor. Being able to cope with these exposures fosters a sense of competence and personal control. Coping skills are also developed or reinforced at this time.

2. It changes the person's cognitive set--or what they "say to themselves" during stress. For example: A child's reaction to an unfamiliar procedure such as an x-ray might be, "No, I don't want to go. It's gonna hurt!" With preparation the child might say to himself, "I know what that is; it's just a machine that takes a picture. It won't

even hurt." This change in cognitive set takes place not only because someone tells the child about the x-ray, which is usually what happens with preparation during hospitalization--but because the child has had the time and experiences to integrate the idea well in advance.

Another feature of stress immunization is that:

3. It provides opportunities for cognitive and behavioral rehearsal. By actively playing with materials and equipment as well as passively observing others, the child can learn about objects and experiences which would otherwise remain unfamiliar and more likely to cause anxiety. CPR training is based on this feature of stress immunization, as are fire and other disaster drills.

4. Another important feature is: Education. Age-appropriate information about the stressor clarifies misconceptions in addition to preparing for the future. Concrete information about hospitalization is especially important for children because of their many fantasies about it. Many children believe that hospitals are places where people go only when they are fatally ill. The way television programs portray hospitals contributes to their ideas.

5. In addition to the just-mentioned features of stress immunization, relaxation training is frequently a part of the process. The ability to relax during a stressful experience is a form of behavioral control and an effective coping mechanism. Children can be taught to learn relaxation techniques which can be supported by parents at the time of hospitalization.

Relaxation tapes which are made specifically for children are available.

The stress-immunization approach has been effective in a variety of non-medical as well as medical situations. For example, it has been applied to anxiety-producing situations such as fear of snakes, injury, airplanes, and death as well as with patients who are depressed or having sexual problems. In addition it has been used to prepare children for surgery and physical examinations. It has also been used to help patients cope with pain.

The stress-immunization approach clearly lends itself to use in preparing children for future hospitalization. The aspects of hospitalization found to be most stressful to children are separation from parents, fear of injury, injection and intrusive procedures. However, for young children who have had relatively few life experiences, most aspects of hospitalization are alien and may be frightening. Preparation for common hospital experiences, such as wearing a johnny and using a bedpan, can be incorporated into a stress-immunization framework.

The second question is: Are there large enough numbers of children hospitalized annually to justify a preparation program?

In 1979 one out of ten children had some contact with a hospital. Each year 3 1/2 to 4 million children under the age of 15 are hospitalized. One-third of all children will spend some time in a hospital by the time they reach adulthood.

Although many children are hospitalized for elective surgery, in many instances children are brought to the hospital because of sudden illness or injury (86% of all hospitalizations of children under the age of five occur on an emergency basis). Because of the sudden nature of the event, there has been no time to prepare them. Even if preparation is attempted

at this time, the child and parents are probably experiencing high levels of anxiety which interfere with these intervention efforts.

Timing preparation, to begin when the child is well, in a familiar and non-stressful setting such as the school, is sound. Not only is preparation of healthy children for possible hospitalization feasible from the standpoint of probability of future exposure, but also this preparation has applicability to other forms of health care such as visits to the doctor's office. This is an experience which also has some stressful aspects and which is experienced frequently by most children. (Children under the age of 18 have an average of four physician contacts per year).

The third question is: Is the experience of hospitalization so stressful that it warrants intervention aimed at lessening its impact? There is ample documentation showing that serious psychological difficulties can result from even brief hospitalization. Although many children do not seem to be affected negatively in terms of visible behavioral changes, many do develop problems such as nightmares, enuresis and changes in behavior such as clinging, aggression or withdrawal. I believe that even if these types of overt responses are not seen, hospitalization usually has a negative effect on most children. This can result in later avoidance of health care because of vivid unpleasant memories and anxieties. (It would be interesting to study this).

Because of the general agreement that hospitalization is a stressful experience, a number of intervention strategies are currently being used. There are all crisis oriented--they take place at the time of hospitalization.

These strategies categorized according to their goals: Those that intend to decrease the degree or duration of exposure to the stress include:

1. 6-hour admission
2. Outpatient care
3. Reduced separation by sibling visitation, rooming-in and 24-hour visitation privileges.

Those strategies that increase coping abilities are:

1. Preparation for surgery, tests and procedures
2. Child life programs which foster adaptation through play and discussion
3. Parental education and involvement in care
4. Encouragement of use of transitional objects

and those strategies which provide external resources are:

1. Increased availability of literature and films on hospitalization and health care
2. Counseling and psychotherapy during and after hospitalization
3. Emotional support from nursing staff
4. Increased availability of community support groups for children and families dealing with specific diagnoses

My proposal for early intervention to supplement these crisis intervention strategies is based on a primary prevention model. It is a pre-crises curriculum which can be implemented in nursery and elementary schools.

The goal of pre-crisis curriculum is to minimize the negative effects of hospitalization on the child and family by reducing their vulnerability to the stress of this experience. This is accomplished by:

1. familiarization with common aspects of hospitalization
2. increasing cognitive and behavioral controls
3. fostering a sense of competence
4. encouraging parental participation and support during hospitalization (as well as during the curriculum)

I will now briefly outline the key elements of the pre-crisis curriculum:

1. Information about typical hospital experiences
2. Experiences with real hospital materials and equipment
3. Parent participation

Information about hospitalization is conveyed by using stress-immunization techniques. These include:

1. Systematic desensitization. Information and experiences are presented according to the hierarchy of least to most stressful. For example, the topic of operations is presented last because it has been found to be especially stressful for children.

2. Modeling: the use of teacher, parent and peer dramatic play episodes. Children observe others they know portraying concern about experiences typically encountered in hospitals, such as having blood drawn. Also films are used in which children portray an ability to cope with stressful hospital experiences.

3. Rehearsal. The children pretend to be patient, nurse, or other health professional in dramatic play situations. During rehearsal, the teacher can clarify misconceptions and suggest way in which children can practice coping skills.

Children who have accurate information are less likely to develop fantasy explanations, which are usually more frightening than reality. Playing with materials and equipment also makes these more familiar and less frightening.

Parent participation is another key element of the pre-crisis curriculum.

Prepared parents are less anxious and better able to support their children at the time of hospitalization. In addition, they can better answer their children's questions and clarify misconceptions about hospitalization in honest yet age-appropriate ways.

Since many parents work or have other commitments, they may not be able to attend class presentations. For these parents, information about the curriculum is sent home and teachers make periodic calls to talk about concerns.

Parent involvement is important in order to:

1. Gain information and ask questions
2. Lessen their own anxieties by clarifying misconceptions
3. Increase their sense of competence through familiarity with the experience
4. Sharing the experience with their child
5. Better able to support child with later hospitalization (increased understanding of needs, concerns of child and their legal rights)

6. See how other parents cope with similar experience

Summary

The pre-crisis curriculum is intended to be a supplement to current crisis-oriented programs. While, unfortunately, the nature of hospitalization will always make it inherently stressful, early preparation of children and parents would contribute to lessening its negative impact.

A great deal remains to be answered regarding the implementation of such a curriculum in schools. Three basic ones are:

1. Who should teach it--teachers, nurses, or other health professionals? (I believe that it should be a collaborative effort between nurses and teachers).

2. How much time should it take--should it be on-going over the entire school year once a week, once a month or less often?

and

3. Exactly what information should be included?

In addition, the behavioral outcomes during and after hospitalization need to be evaluated. These would include:

1. Child's adaptation to the hospital
2. Recovery from surgery or illness
3. Post-hospital adjustment

Parent advocacy goals would be evaluated in terms of parental:

1. Responses to child during hospitalization
2. Ability to support child
3. Awareness of their rights and knowledge of resources available to them within the hospital.